

**“That Never Would Have Occurred To Me”:
A Qualitative Study of Medical Students’ Views
of a Cultural Competence Curriculum**

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Abstract

Background. The evidence is mixed regarding the efficacy of cultural competence curricula in developing learners' knowledge, attitudes and skills. More research is needed to better understand both the strengths and shortcomings of existing curricula from the perspective of learners in order to improve training. **Methods.** We conducted three focus groups with medical students in their first year of clinical training to assess their perceptions of the cultural competence curriculum at a public university school of medicine. **Results.** Students reported some success in translating certain aspects of both the formal and informal curriculum into the clinical arena, but less success in others. Students were concerned that a cultural competence curriculum might stereotype or overgeneralize about patients from other cultural backgrounds, but also wanted to receive precise, "scientific" learning that could resolve their confusion about cross-cultural encounters. Despite some concerns as to whether political correctness characterized the cultural competence curriculum, it was also seen as a way to rehumanize the medical education experience. **Conclusions.** Future research needs to pay attention to issues such as perceived relevance, stereotyping, and political correctness in developing cross-cultural training programs that effectively translate training into clinical performance.

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Background

Cultural competency instruction in medical education has been the thrust of several recent reports in the US and the UK [1,2,3]. Evidence is growing that improving cross-cultural communication skills in healthcare providers is associated with better patient outcomes [4,5] and has the potential to reduce health disparities [6] and access to care inequities [4]. However, a recent systematic review evaluating cultural competence training of health professionals [7] concluded that lack of methodological rigor made it difficult to draw conclusions regarding the effectiveness of specific educational interventions.

Attitudes of students toward diversity training have been examined using, for example, the Cultural Diversity Attitude Scale [8,9] but such studies are still relatively few in number [10]. Existing research has shown that learners evaluate their cross-cultural curricula both positively and negatively. For example, one study concluded that, while many residents endorsed the importance of cross-cultural competency, most noted that there was still a lack of “formal” education on this topic, and that they were poorly prepared to deal with cross-cultural clinical encounters [11]. In another study, much of learners’ self-reported cross-cultural competency came from their own improvisational coping [12].

While a few studies have provided evidence that medical students’ knowledge and skills can be positively changed as a result of participation in a cultural competency curriculum [13], others suggest that exposure to a cross-cultural curriculum has little or no effect on student skill acquisition. For example, Beagan [14] found that students

participating in a course designed to improve cultural and social sensitivity did not show any measurable increased awareness compared to nonparticipating students. As reported in a UK study [15], one cultural competence curriculum produced only a superficial awareness of multicultural issues in students. In another study, learners reported having adequate cross-cultural communication skills and training, but felt both systemic and culture-bound factors inhibited providing quality care [16].

Learners appear to have significant concerns about the content and structure of existing cultural competence curricula. According to one study, learners were concerned that stereotyping of different racial and ethnic groups would be an unintended consequence of formal cross-cultural education [12]. In another study, students felt that the cross-cultural curriculum should have a more practical orientation with less emphasis on theoretical issues [15].

Information from medical students regarding the effectiveness of cultural competence curricula is crucial in designing meaningful educational experiences. As suggested by the literature cited above, we still do not have sufficient information from the perspective of students regarding their cultural competence curricula. Qualitative studies may be particularly useful in this respect. Compared to survey instruments, for example, a qualitative approach has the advantage of eliciting views about informal as well as formal curriculum, and providing in-depth and diverse viewpoints about students' subjective experiences and perceptions [17].

The purpose of the study reported below was to assess the views of third year medical students at a public university school of medicine regarding its cultural competence curriculum (CCC). The CCC incorporated recommended curricular

guidelines such as an integrated longitudinal approach [18], concepts of cultural humility [19,20], and specific communication tools [21]. We wished to assess 1) students' understanding of the meaning of cultural competence 2) students' perceptions of the efficacy of the CCC 3) the extent to which the CCC prepared them for cross-cultural encounters during their first clinical year and 4) students' suggestions for improvement of the CCC. We were particularly interested in learning about specific examples of the translational process from didactic/small group teaching to the clinical environment.

Methods

Participants were 16 third year medical students, or 17.4% of the entire class. There were 6 males and 10 females (62.5%), a somewhat higher representation of women compared to the student body as a whole (50.0%). The focus groups also included 17.7% underrepresented minorities, again a somewhat higher representation than in the student body as a whole (10.0%). Students were recruited via a series of emails as well as personal recruitment during an examination by a faculty member not otherwise connected with this study or the CCC. Students were offered the incentive of a free lunch, and participated in a raffle for which the prize was a medical textbook. Sampling was in part purposive, in that efforts were made to attract students with a wide range of attitudes toward cultural competence training, including students with intense feelings about the subject, both positive and negative, and students with less interest in the topic. Specifically, the first two authors urged students whom they perceived to represent any of these three positions to participate in the focus groups. Sampling was also partly a matter of convenience, since we had to accept all students who volunteered, then contend with demanding rotation and examination schedules.

Nineteen students responded affirmatively. Two could not attend the focus groups due to scheduling conflicts, but agreed to participate in individual interviews. Three others could not arrange either focus group participation or interviews. The three focus groups contained respectively 5, 5, and 4 students. All participating students had had a high degree of contact with patients from different cultural backgrounds. This study was approved by the university's human subjects institutional review board. Following the requirements of that approval, the nature and purpose of the study was carefully explained in the recruitment email. The study was again explained at the start of each focus group, including issues of anonymity and confidentiality regarding tape-recording and transcription of tapes, as well as reporting of findings; and verbal consent was obtained from group participants, which was recorded as part of the focus group session. Since consent was inferred from response to the recruitment email (students could refuse to participate simply by not replying) and to the oral presentation of the study by the faculty member, our IRB considered verbal reiteration of consent sufficient.

A preliminary version of the schedule of focus group questions was developed by a researcher (JS) trained in focus group methodology, who has also conducted previous research on cultural competence in medical learners [15,16]. This interview guide was reviewed and modified by the second author (DL) who directs the Patient Doctor course in which some of the Cultural Competence Curriculum was embedded. The groups followed standard focus group methods, including creating a comfortable atmosphere, allowing conversation to flow naturally rather than adhering to a strict schedule, encouraging differences of opinion, eliciting comments from silent members, and summarizing and clarifying main points with each group before it disbanded [22]. The

location of the focus groups was a small, comfortable conference room in the researchers' home department. In accordance with focus group guidelines, a moderator was the primary facilitator and an assistant moderator (an undergraduate student [DG]) made process notes and observations, as well as asked clarifying and supplemental questions as needed. Each group was approximately 75 minutes in length and was tape-recorded. The individual interviews were conducted by DG by telephone. These interviews used the same interview guide prepared for the focus groups, and lasted about 20 minutes. All recordings were then transcribed verbatim, and these texts, in addition to the group process notes, and written notes from the interviews, provided the basis for data analysis.

Data analysis. As is typical in qualitative research [23], data gathering and data analysis occurred to some extent simultaneously, in the sense that the two focus group facilitators discussed their impressions of each group immediately upon its completion and adapted the interview guide to better reflect student concerns. JS kept notes of these debriefings to establish an audit trail. In addition, at the end of each focus group, JS summarized the main points of the discussion, and asked groups to confirm and/or modify this summary. After the focus group discussions were transcribed, all members of the research team performed an independent systematic analysis of each transcript, coding first key words and phrases based on the interview guide, then reexamining these to generate new categories that eventually produced essential themes [24], which in turn were shared and discussed by all authors. We achieved theoretical triangulation in the analysis phase due to our range of perspectives and experience: physician, psychologist, pre-medical student, and post-graduate sociology major. Theoretical triangulation (25) is important because it requires that more than one theoretical position is used in

interpreting data. Resolution of disagreements was obtained through face-to-face and email discussion. The independent analyses prepared by each researcher were integrated by JS to represent a comprehensive synopsis representing our consensual process. The research team then reviewed and modified this document to identify the themes and interpretations reported below [26]. This approach was intended to balance out the inevitable biases that we inevitably introduced into our own individual analyses because of our stage of professional training, type of professional training, personal cultural backgrounds, and life histories. The subheadings below represent both concepts and issues based on the interview schedule and those that emerged independently from the data analysis process.

Results

Definition of cultural competence. Students saw cultural competence as having the attitudes, knowledge, and skills to effectively interact with and care for patients from different cultural backgrounds. It appeared from student statements that “effective interaction” meant that understandable communication occurred, common ground was established in terms of diagnosis and prognosis, students were able to establish rapport and gain patient trust, and both patients and students were satisfied with the encounter. While ethnic/racial diversity was one component of cultural competence, students emphasized the importance of being familiar with other areas of diversity, including sexual orientation, mental illness, disability, the culture of poverty and the culture of medicine.

Students’ perceptions of the CCC. All of the focus groups agreed that the CCC consisted of both formal and informal elements. Formal elements of the curriculum most

frequently mentioned were a required reading assignment [27], a standardized patient module of an interpreted interview; and various required role-play situations that contained a cultural component. Lectures about cross-cultural topics were also mentioned, although less frequently. The basic sciences were never identified as a place where cultural competence education occurred. According to students, the informal curriculum included the following components: 1) learning from residents and attending physicians in clinical situations 2) learning from patients in clinical situations and 3) learning from the diversity of fellow students.

Overall, most students evaluated both the formal and the informal CCC as useful and relevant. The aspects of the formal curriculum that they remembered seemed effective. They agreed that, in terms of the informal curriculum, there were both good and bad resident and attending role-models, but that in general they learned a lot about cultural competence in the clinical settings. Of note is that the two students interviewed separately were more negative about the CCC, which they appeared to interpret as primarily the formal curriculum.. One student described the curriculum as “not that great, superficial, didn’t provide any concrete skills. There was nothing new. Honestly, I was very frustrated with the superficiality.” The other student responded, “Overall it was pretty poor. There was not really anything new that I didn’t know before.”

Strengths of the CCC. Students believed that the first two years of medical school were successful in conveying the idea that people can hold very different perspectives about the same problem, and that such different perspectives must be both respected and reconciled. Students also felt that the communication skills learned through a combination of didactic presentations and small group exercises in the first year were

very useful in cross-cultural interactions and that these skills translated well across cultures. Finally, they rated highly a module plus group discussion on how to use an interpreter.

The informal curriculum was considered superior to the formal curriculum in terms of achieving cultural competence because of the direct link it provided between knowledge presentation and skill acquisition. As one student expressed it, “I think the greatest part [of CCC] is seeing by example how to act, or act in a certain situation.” Another student said, “I’m learning more on the go [about CCC], in clinic from my preceptor. And I’ve learned more in the clinic actually than I ever did in any lecture that I had, if I think back.” A third representative comment follows: “I guess what I’m trying to say is that you really learn when you’re thrown in these situations. Like right now I have a lot of Vietnamese patients and I’m learning for the first time about Vietnamese and their culture and just different ways that they need to be treated as a patient, things you need to be sensitive about. But it’s only because I’m working with these patients.” However, several students noted that attending physicians rarely had time to talk about cultural issues.

Many students mentioned that one of the strongest aspects of the informal curriculum was the diversity of the student body. They seemed to feel that, because they were surrounded by diversity, they could not be biased. As one student put it, “A different generation might not have had this advantage. But young people nowadays, we’re all so diverse, we’re used to being with people from other backgrounds since elementary school, it’s no big deal.” The diversity of the patient population and of the faculty also encouraged students to think about different cultures.

Weaknesses of the CCC. Despite their general satisfaction with the CCC, students were able to identify numerous weaknesses. In particular, they felt the definition of cultural competence was too narrowly restricted to different ethnic groups. A few felt the curriculum failed to capture the interest of students not already committed to cultural competence. In terms of the pre-clinical years, several students felt there was insufficient effort to make the CCC directly relevant to patient care.

During the third year, the opportunities for clinical teaching about cultural issues in the patient environment were underutilized. For example, although students' clinical training occurred in a culturally diverse environment, this aspect was not commented on during teaching opportunities *in a systematic way*. Students felt that while some of their best, most practical cultural competence teaching took place in the clinics or hospital, it happened randomly, varying significantly from one rotation, one clinic, or even one resident or attending to another. Cultural competence was rarely if ever the main focus of teaching, but rather an afterthought or an add-on. As one student noted, "I'm sure I do [make culturally insensitive mistakes], but I don't know what they are because no one's ever watched me and said you're doing this and how to be constructive about it."

Self-awareness as a component of cultural competence. It was initially difficult for students to connect self-awareness to culturally competent patient care. After some probing, however, several students were able to give specific examples of how they had become aware of their own biases as a result of exposure to both the formal and informal curricula. One student (himself Vietnamese) commented that the CCC had enabled him to develop a more professional perspective in considering patient health beliefs: "And that [the CCC], when I was talking with them [Vietnamese patients], kept me from like..."

just laughing you know, making an inappropriate response when they would express these unscientific beliefs” In the words of another student: “...[This was] something that the [CCC] originally made me aware of, because that never would have occurred to me [i.e., the possibility that she could have personal prejudices]. I think that I’m an empathetic person and that I would go into every encounter with an open heart but as it turns out I really do have a harder time with certain patients.”

Translational aspects of the CCC. Some aspects of the CCC appeared to translate into the clinical setting better than others. Areas such as how to use an interpreter and how to use communication skills with a patient that had received detailed behavioral attention in the curriculum seemed to easily be transferred to interactions with actual patients. However, areas that were less easy to reduce to specific behaviors and which involved potential conflict proved more baffling. For example, students reported that they knew how to elicit patient health beliefs and were able to give several examples of specific knowledge they had acquired, such as the Vietnamese belief that wind can cause illness; but they did not feel they were adequately prepared by their training to know how to integrate and deal with these beliefs in the clinical context.

In another example, students commented that faculty and residents sometimes demonstrated stereotypic, denigrating attitudes toward patients of a specific ethnicity. “Some residents talk about patients doing the Macarena, which means Latina women in labor who are loud.” “A lot [of residents, attendings] are judgmental, a lot are stereotypical.” They also reported instances of bias in patients: “I had a patient just today who told me that I couldn’t understand his anger because I’m white and in the Korean population that’s how they deal with conflict is they get angry/violent.” And examples of

unfair *positive* bias in faculty were also reported: “Sometimes you see, like examples of physicians who are kind of more biased toward patients who are of their own culture. I remember this one rotation where this doctor would spend half an hour on one patient that was of his culture, the whole time speaking that language... and then in comparison he would spend 5 minutes with patients of various different cultures...”

Students had no difficulty identifying such examples as race-based stereotyping, and attributed their awareness in part to learning that occurred in the CCC. But they varied in their ability to *address* or respond to these situations, despite teaching proactive behavior in the face of racism being a goal of the CCC. One woman said she could not say anything because the faculty was “intimidating.” On the other hand, a couple of students reported that they often ‘spoke up’, but did so in a style that avoided confrontation. On the whole, students across the three groups did not appear well-prepared to deal with these situations in the real world.

Specific recommendations to improve the CCC. Students agreed that exposure to the CCC during the first two year of training should include patient care experiences that emphasized the relevance of understanding cultural differences. There was also a widespread feeling that students would pay much closer attention to cross-cultural information during the third (clinical) year when they were confronted with patients of different cultural backgrounds on a daily basis. There was consensus that the CCC should be integrated into clinical practice in a more systematic way.

Many students suggested using patients as teachers. This point emerged both in talking about the formal curriculum (more use of standardized patients; more patient panels); and the informal curriculum (learning to ask patients for feedback in terms of

what the student was doing right or wrong). In the words of one enthusiastic student, “Patients are the best teachers.”

Another idea popular with the first two groups was that students would learn about cultural diversity from each other, because of the diverse nature of the student body. In the third group, students felt that self-disclosure exercises were more a way of getting to know each other, rather than learning about different cultures. Overall, students felt that utilizing the diversity of the students was best left as part of the informal curriculum.

Finally, although these students all valued the concept of cultural competence, none suggested that we test for this competency through either written or clinical examination.

The above topics were directly related to the study interview schedule. However, in addition to issues about which students were asked explicit questions, three categories emerged spontaneously in 2 of the 3 groups: cultural “balance,” political correctness, and humanizing influence of the CCC.

The search for cultural “balance.” Many students wanted group-specific knowledge about as many different cultures as possible. In the words of one student, “I always feel like part of my knowledge is lacking... I know I should be sensitive to different things of their healthcare but I don’t really know what they are...” A student from a different group said, “I mean I know the task may be very daunting, but it would be insightful if I knew about as many cultures as possible...” They wanted this information to include beliefs and “misconceptions” patients from different cultural backgrounds held about illness and medicine.

While many students seemed eager for group-specific cultural knowledge, others expressed concern that such presentations might stereotype different ethnicities. One

student said, “Sometimes I think it’s better when I go into a [n exam] room and figure the patient out for myself without any preconceived notions of ‘Oh, this patient is Hispanic so she’s going to act this way.’” Another noted, “As soon as you start you know, painting a certain ethnicity as, you know, look out for these, you’re basically saying every person who is this ethnicity has this.”

These students called for a “balance” between acquiring appropriate cultural knowledge and approaching each patient as an individual. One student summarized this point of view in the following way: “To me it’s the balance, because we’re told on one hand that you treat all these patients as patients, you know it doesn’t matter where they’re from... On the other hand, we’re told if they have a certain ethnicity there are all these other things we need to think about.”

Does the CCC promote political correctness? There was a difference of opinion about the openness of the student body to discuss sensitive issues of culture. On the one hand, some students’ perception was that their peers felt comfortable “being themselves” and expressing their cultural and religious beliefs. “My experience is that people have been themselves and let their religion or their culture or whatever, come out.”

However, other students felt that the whole discussion of culture was overlaid by a strong degree of political correctness, so that it was difficult for people to state their true opinions or feelings. “We’re all taught to be so politically correct these days and no one wants to say how they really feel. Like it was hard for me to admit I had certain biases about certain cultures but I do...”

In general, we did not detect reliable differences in students based on either gender or ethnicity. However, it is worth noting that it was non-Hispanic white students

who appeared most concerned about political correctness inhibiting their expression of opinions and most eager to endorse approaches which emphasized individual people rather than cultural groups; whereas students from various minority backgrounds were most insistent as to the importance of the CCC.

The CCC and humanism. Several students were concerned about the decline in humanistic values during their third year. In the words of one student, “When I go home I just don’t think about patients, I think about their medical issues. There have only been a few times when I actually start to think what I call ‘personal connection,’ where I go you know I wonder how it’s affecting their life, I wonder how they’re really feeling.” As a kind of antidote, students felt it was important that “[Aspects of the CCC] showed that the medical school actually cares about culture and people, you know.” The implication was that the CCC could reinvigorate students with a more patient-centered approach.

Discussion

Several aspects of these discussions with third year medical students were illuminating. One was the strong preference expressed across all three groups for the majority of the CCC to be integrated into the informal curriculum, especially during the third year of training, when students start their clinical rotations. Students appeared to feel that they learned best when cultural issues were part of specific patient encounters and clinical issues. They argued that such an approach would appeal to peers who had no particular interest in cross-cultural issues, but who would be forced by need to pay attention to and learn skills that would help them solve difficult interactions with patients from different cultural backgrounds on a daily basis. It also seemed to be the case that

many students believed they learned better in this type of integrated environment, where knowledge had immediate and direct application.

Although this is an attractive proposition, it faces the perpetual challenge of how to systematically train large numbers of attendings and residents in all the steps of cultural awareness, sensitivity, knowledge, attitudes, and skills; and most importantly, how to teach them to simultaneously attend to medical and cultural issues in any given patient encounter. Unfortunately, too many in teaching positions still perceive such material as peripheral to their “real” function of providing instruction in biomedicine.

The fact that no student advocated assessment of the cultural competence curriculum deserves some reflection as well. This omission may mean nothing more than students’ understandable aversion to yet more examination in an already test-intensive academic environment. It may also intimate that students do not perceive cultural competence as “real learning” on a par with the basic sciences and clinical knowledge. Students may also see cultural competence in much the same way good communication used to be viewed, as something one either has or doesn’t have. Finally, it is possible that students’ attitudes toward cultural competence evaluation reflect those of many medical educators who have concerns about how to meaningfully approach the question of evaluation [28].

Overall, it appeared that some translational aspects of the CCC were fairly successful, specifically very concrete, tangible behaviors such as how to make use of interpreters and how to apply communication skills in patient encounters [29]. Students were less sure of how to handle more nebulous issues such as integrating differing health beliefs or dealing with expressions of bias. On the one hand, this makes sense, as

behavioral skills which are overlearned in OSCE-type settings are probably most easily transferred to actual clinical situations. However, this finding suggests that the “heart and soul” of cultural competence may not find simple expression in clinical environments, because students are less sure how to put abstract values and attitudes into practice.

In terms of the content of culturally competent training, students expressed a desire for concreteness and certainty in cross-cultural knowledge which was precariously balanced against their awareness of the dangers of overgeneralizing and stereotyping groups. Generally speaking, students did not appear to have theoretical models other than culture, such as power and privilege [30], within which to understand the relationship between doctors and patients. Instead, they seemed to try to avoid stereotyping by ignoring cultural difference, and treating patients “equally,” regardless of cultural background.

However, a few students made intriguing out-of-the-box suggestions. For example, one student proposed that, instead of emphasizing cultural difference, we should focus on negotiating skills and conflict management (31). In this conceptualization, cultural difference produces conflicting viewpoints, opinions, and proposed actions. Therefore, intervention focused on conflict resolution would be more valuable than simply acquiring knowledge about different cultures. Another student proposed that by adopting a position of respectful curiosity about a person’s background, regardless of particular culture, students could position themselves as learners and patients as teachers. This posture of cultural humility (32) was offered as a viable alternative which would respect individual differences within culture while educating students about a wide array of cultural practices.

Students seemed to find reassurance in the fact that they were training in a culturally diverse environment. However, there are several problems with the assumption that environmental diversity ensures lack of bias. First, although it is true that the student body has many first and second generation students from diverse cultural backgrounds, it has no greater presence of underrepresented minorities than other U.S. medical schools. Further, there tends to be more homogeneity than heterogeneity in terms of academic ability and socioeconomic status in medical school. In addition, the medical school experience is known for its capacity to “stamp out” the diversity of those who succeed in matriculating. In other words, medicine allows little room for diverse students to be all of who they are while in medical school (33). Finally, although students may be used to the concept of diversity through exposure to peers from different cultural backgrounds, to truly utilize the knowledge gained from this exposure, they must be willing to cultivate empathy for values and priorities different from their own and honestly face their own stereotypic assumptions. In this regard, it was disturbing to note that students had difficulty in recognizing the relevance of self-awareness to cultural competence, while at the same time providing multiple examples of their own biases.

Because of differences in opinion as to whether the CCC operated in a context of political correctness, it was unclear to what extent students either confronted their own biases or developed respectful understanding of culturally different perspectives. While some participants maintained that students could “be themselves” and express opinions openly, a significant minority maintained that they were tightly bound by certain norms that made it unacceptable to verbalize culture-based negative attitudes. This allegation is of particular concern because it reinforces the (fallacious) belief that students can assume

a “professional” demeanor at work while indulging racially or culturally based biases in the safety of their private lives. Such beliefs could seriously impede the ability of the CCC to penetrate more than superficial levels of student attitudes, leading to conformity to perceived norms rather than genuine respect and understanding of difference. While the presence of political correctness in medicine does not get much play in U.S. journals, British journals have occasionally published articles raising questions as to whether political correctness can compromise the quality of physician training or patient care (34), and it seems a more open discussion of this issue is needed.

Despite concerns about the CCC, many students regarded it as a method for humanizing their medical education. This link between the CCC and humanism is an interesting one, and has been noted by others. For example, one author suggests that culturally competent care and patient-centered care (based on several humanistic properties) are philosophically similar and both contribute to patient empowerment (35). It is possible that the CCC helped to connect students to the life stories of their patients, particularly as these were manifested in the informal curriculum, and this experience had a rehumanizing effect.

Limitations. We were disappointed that despite determined recruitment efforts, only a small number of the class chose to become involved in this project. We believe that we were successful in attracting both students who cared passionately about the CCC, those who had less interest in it, and those who held significant reservations. Nevertheless, the majority of the students who participated appeared to hold positive views about their cultural competence training. This conclusion suggests that another limitation of our study may have been the focus group format itself. We were struck by

the significantly more negative perceptions shared in the two individual interviews. Although students in the focus groups certainly expressed negative sentiments about the CCC, these were generally balanced by positive and constructive comments. For reasons we could not perceive, the focus groups might have attracted more pro-social, “helpful” types of students, the kind who always volunteer for extracurricular activities. The two students in the individual interviews, by contrast, might have been outliers who chose to express views privately that they felt to be at variance with group norms. The greater anonymity of a phone interview may have freed them to be more critical. Nevertheless, the diversity of opinions expressed during the group discussions provided some reassurance that, despite the small number of students, we did succeed in sampling widely differing viewpoints about the CCC.

Conclusions

Students in this study reported some success in translational aspects of both the formal and informal curriculum. They evaluated most positively highly concrete aspects of the CCC, and wanted more practical ways to learn about the subject of cultural competence and fewer lectures or didactics. They suggested more explicit teaching in the clinical setting, by knowledgeable faculty and other clinical teachers. Students were worried about stereotyping or overgeneralizing about patients from other cultural backgrounds, but also yearned for precise, specific, “scientific” learning that could finally resolve their confusion and uncertainty about cross-cultural encounters. Despite some concerns as to whether political correctness permeated the CCC, it was also perceived as one way of rehumanizing the medical education experience.

List of Abbreviations

CCC – Cultural Competence Curriculum

IRB – institutional review board

Competing Interests

The authors declare that they have no competing interests.

Authors' Contributions

DL and JS developed the initial conceptualization of the study and worked together to develop the research questions and the question route. DL developed the participant recruitment strategy, which was implemented by DG. DG conducted the literature review under the guidance of DL and JS. JS conducted all focus groups, and was assisted by DG, who also took observational field notes during each session. DG also conducted the two individual interviews. JS and DG debriefed together after each focus group. DG transcribed all group and individual interviews. JS formulated the data analysis plan, and all authors reviewed and prepared theoretical notes on all transcripts. Each author prepared an initial analytic summary, which were then integrated and interpreted by JS. All authors reviewed and modified a final interpretive summary. JS prepared the initial draft of the manuscript, which was revised by DL, DG, and GG. All authors read and approved the final manuscript.

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